Guide

To Health Insurance for People with Medicare

1989

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Some Basic Things You Should Know

Hints on Shopping for Private Health Insurance

Types of Private Health Insurance

What Medicare Pays and Doesn't Pay

Developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration of the U.S. Department of Health and Human Services.

#1

THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988 (PUBLIC LAW 100-360) MANDATES VARIOUS CHANGES IN THE MEDICARE PROGRAM TO BETTER PROTECT THE 32 MILLION ELDERLY AND DISABLED BENEFICIARIES FROM CATASTROPHIC OR EXTRAORDINARY HOSPITAL, DOCTOR AND PRESCRIPTION DRUG BILLS.

BECAUSE THESE CHANGES ARE TO BE PHASED IN OVER THE NEXT FEW YEARS, THE MEDICARE INFORMATION IN THIS PAMPHLET IS FOR 1989 ONLY. THE PAMPHLET WILL BE UPDATED ANNUALLY TO REFLECT CHANGES IN THE PROGRAM AS THEY OCCUR.

AS THE NEW MEDICARE BENEFITS ARE INTRODUCED, INSURERS WILL CHANGE THEIR BENEFIT PLANS AND PREMIUMS. YOU MAY WISH TO RE-EVALUATE YOUR INSURANCE NEEDS BASED ON YOUR HEALTH STATUS AND FINANCES AS THESE CHANGES TAKE EFFECT.

NOTICE

LISTED IN THE BACK OF THIS PAMPHLET ARE THE ADDRESSES AND TELEPHONE NUMBERS OF EACH OF THE STATE AGENCIES ON AGING AND THE STATE INSURANCE DEPARTMENTS. THEY ARE AVAILABLE TO ASSIST YOU WITH ANY QUESTIONS YOU MAY HAVE ABOUT PRIVATE INSURANCE TO SUPPLEMENT MEDICARE. SUSPECTED VIOLATIONS OF THE LAWS GOVERNING THE MARKETING OF THESE POLICIES SHOULD BE REPORTED TO YOUR STATE INSURANCE DEPARTMENT OR FEDERAL AUTHORITIES. THE FEDERAL TOLL-FREE NUMBER FOR REGISTERING SUCH COMPLAINTS IS:

1-800-888-1998

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Developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration of the U.S. Department of Health and Human Services.

SOME BASIC THINGS YOU SHOULD KNOW—Medicare pays a large part of your health care expenses, but it does not pay them all. There are limits on Medicare payments for some covered services and medical supplies. You also must pay certain amounts called deductibles and co-payments.

There are some services which are not covered either by Medicare or most private insurance. For example:

- Custodial care in a nursing home or at home is not covered by Medicare or most private insurance policies on the market today. (See page 12.)
- Medicare and most private health insurance policies pay only a specified percent of the amount approved by Medicare. You pay the rest, including any charges in excess of those approved by Medicare. To avoid extra charges, ask your doctors or medical suppliers, such as laboratories and therapists, if they participate in Medicare or accept assignment of Medicare benefits. Assignment means that your doctor or other medical supplier has agreed to bill Medicare and accept the amount approved by Medicare as the total payment for services and supplies covered by the program. Participating doctors and suppliers accept assignment on all Medicare claims. (See page 22.)
- Insurance to supplement Medicare, commonly called "Medigap" insurance, is not sold or serviced by the Federal or State governments. Do not believe advertising or agents who suggest that Medicare supplement insurance is a government-sponsored program.

Before you consider buying insurance to supplement Medicare, you should know what Medicare benefits are. Pages 14 through 26 explain your Medicare coverage. Please review them carefully.

DO YOU NEED PRIVATE HEALTH INSURANCE IN ADDITION TO MEDICARE?

Not everyone does . . .

- If you are a Medicare beneficiary enrolled in a prepayment plan, such as a health maintenance organization (HMO) or competitive medical plan (CMP), which has a contract with Medicare, you may not need a Medicare supplement policy. (See page 9.)
- Low-income people who are eligible for Medicaid generally do not need additional insurance. Individuals who are eligible for regular Medicaid benefits qualify for certain health care benefits beyond those covered by Medicare, such as long-term nursing home care.
- The recently enacted Medicare Catastrophic Coverage Act of 1988 provides some limited financial assistance through Medicaid for paying your share of acute care costs if you are not otherwise eligible for Medicaid and you meet certain income and resource tests. If your annual income level is below the national poverty level ($5,770 for one person or $7,730 for a family of two) and you do not have access to many financial resources, you may qualify for government assistance in paying the Medicare premium, and at least some of the Medicare deductibles and co-payments. The maximum annual income for qualification may vary

by State. If you qualify, this financial assistance will be offered through your State's medical assistance (Medicaid) program sometime after January 1, 1989. The date of availability will vary from State to State. If you think you may qualify, you should contact your State or local social service agency.

- Whether you need health insurance in addition to Medicare is a decision which you should discuss with someone you know who understands insurance and your financial situation. The best time to do this is before you reach age 65.

HINTS ON SHOPPING FOR PRIVATE HEALTH INSURANCE—Shop Carefully Before You Buy . . . Policies differ widely as to coverage and cost, and companies differ as to service. Contact different companies and compare the policies carefully before you buy.

Don't Buy More Policies Than You Need . . . Duplicate coverage is costly and not necessary. A single comprehensive policy is better than several policies with overlapping or duplicate coverages.

Consider Your Alternatives . . . To better meet your health care needs, consider continuing the group coverage you have at work; joining an HMO, CMP or other prepayment plan; buying a long-term care insurance policy; or buying a Medicare supplement policy. (See pages 8 through 14.)

Check For Preexisting Condition Exclusions . . . Which reduce or eliminate coverage for existing health conditions. Many policies exclude coverage for pre-

existing health conditions. Preexisting conditions are generally defined as those conditions for which medical advice was given or treatment was recommended by or received from a physician before the effective date of your coverage under an insurance policy.

Most State laws require Medicare supplement policies to cover preexisting conditions after the policy has been in effect for 6 months.

Don't be misled by the phrase "no medical examination required." If you have had a health problem, the insurer might not cover you for expenses connected with that problem.

Beware of Replacing Existing Coverage . . . Be suspicious of a suggestion that you give up your policy and buy a replacement. Often the new policy will impose waiting periods or will have exclusions or waiting periods for preexisting conditions covered by your current policy. On the other hand, don't keep inadequate policies simply because you have had them a long time. You don't get credit with a company just because you've paid many years for a policy.

Be Aware of Maximum Benefits . . . Most policies have some type of limit on benefits which may be expressed in terms of dollars payable or the number of days for which payment will be made. Keep in mind that some insurance policies pay less than the Medicare approved amount (or nothing) for hospital outpatient medical services or services in a doctor's office.

Check Your Right to Renew . . . Beware of policies that let the company refuse to renew your policy on an individual basis. These policies provide the least permanent coverage.

Most policies cannot be canceled by the company unless all policies of that type are canceled in the State. Therefore, these policies cannot be canceled because of claims or disputes. Some policies are guaranteed renewable for life. This means that although your insurance premiums may be adjusted from time to time, the insurance company cannot cancel your coverage. Policies that can be renewed automatically offer added protection.

Be Aware That Policies to Supplement Medicare Are Neither Sold Nor Serviced by the State or Federal Governments . . . State Insurance Departments approve policies sold by insurance companies but approval only means the company and policy meet requirements of State law. Do not believe statements that insurance to supplement Medicare is a government-sponsored program. If anyone tells you that he or she is from the government and later tries to sell you an insurance policy, report that person to your State Insurance Department or Federal authorities (see pages 27 to 30). This type of representation is a violation of Federal and State law. It is also unlawful for a company or agent to falsely claim that a policy has been approved for sale in any State in which it has not received State approval, or to use fraudulent means to gain approval.

Know With Whom You're Dealing . . . A company must meet certain qualifications to do business in your State. This is for your protection. Agents also must be licensed by your State and may be required by the State to carry proof of licensure showing their name and the company they represent. If the agent cannot verify that he or she is licensed, do not buy from that person. A business card is not a license.

Keep Agents' and/or Companies' Names, Addresses and Telephone Numbers . . . Write down the agents' and/or companies' names, addresses and telephone numbers; or ask for a business card that provides all that information.

Take Your Time . . . Do not let a short enrollment period put pressure on you. Professional salespeople will not rush you. If you question whether a program is worthy, ask the salesperson to explain it to a friend or relative whose judgment you respect. Allow yourself time to think through your decision.

IF YOU DECIDE TO BUY—**Complete The Application Carefully** . . . Some companies ask for detailed medical information. If they do and you omit the requested medical information, the company can refuse coverage for an omitted condition for a period of time or it may deny a claim and/or cancel your policy. Do not believe anyone who tells you that your medical history on an application is not important.

Look for an Outline of Coverage . . . You should be given a clearly worded summary of the policy . . . READ IT CAREFULLY.

Do Not Pay Cash . . . Pay by check, money order or bank draft made payable to the insurance company, not to the agent or anyone else.

Check For a "Free-Look" Provision . . . New standards that go into effect nationwide by September 20, 1989, or earlier if a State acts to implement them, require insurance companies to give you at least 30 days to review a Medicare supplement policy. If you decide you don't want

the policy, send it back to the agent or company within 30 days of receiving it and you will be entitled to a refund of all premiums you paid. Contact your State Insurance Department if you encounter a problem in obtaining a refund.

Until the new standards go into effect, companies are required to give you 10 days from the date of delivery to review a Medicare supplement policy purchased directly from an agent, or 30 days if it was purchased through the mails or in response to a mass media solicitation.

Policy Delivery or Refunds Should be Prompt . . . The insurance company should deliver a policy within 30 days. If it does not, contact the company and obtain in writing a reason for the delay. If 60 days go by without information, contact your State Insurance Department.

For Your Protection . . . Federal criminal and civil penalties as well as State penalties can be imposed against any company or agent who knowingly sells you a health insurance policy that substantially duplicates coverage you already have, but will not pay benefits if your medical expenses are covered by another insurance policy or Medicare. There are also penalties for claiming that a policy meets legal standards for certification when it does not, and for using the mail for the delivery of advertisements of Medicare supplement health insurance policies that have not been approved for sale in a State. It is also unlawful for a company or agent to suggest that they represent the Medicare program or any Government agency. If you believe you have been the victim of these or any other illegal sales practices, you should contact your State Insurance Department

(see pages 27 to 30) or call the toll-free hot line maintained by the U.S. Department of Health and Human Services. The toll-free number is 1–800–888–1998.

You should also report the misuse by any individual or company of the names, letters, symbols or emblems of the U.S. Department of Health and Human Services, the Social Security Administration, or Health Care Financing Administration. A new Federal law prohibits the use of these agencies' identifying marks and names or variations of them to falsely claim or suggest that they have approved, endorsed or authorized any item, including insurance policies.

TYPES OF PRIVATE HEALTH INSURANCE—Private health insurance is available through group and individual policies. It is offered by some companies through agents and by other companies directly through advertising media and mail. The value and extent of coverage differs widely among both group and individual policies.

Types of individual and group health insurance coverages:

- **Medicare Supplement Insurance** . . . Pays some or all of Medicare's deductibles and co-payments. Some policies may also pay for some health services not covered by Medicare. The National Association of Insurance Commissioners (NAIC) has revised its model regulation to include new minimum benefit standards for Medicare supplement policies. It requires that as a minimum benefit, Medicare supplement policies include:

Coverage of all or none of the Medicare Part A deductible, which is $560 in 1989.

Coverage for the co-payment amount required under Part A for the first eight days of care in a skilled nursing facility. The co-payment is $25.50 a day in 1989.

Coverage for the blood deductible under Part A, unless the blood is replaced.

Coverage for the 20% co-payment under Medicare Part B up to $5,000 after you pay Medicare's $75 deductible and the first $125 of Medicare co-payments.

To determine when revised minimum benefit standards go into effect in your State, consult your State Insurance Department (see pages 27 to 30).

Some policies may also pay for some health services not covered by Medicare (See page 14.) Medicare pays only for services determined to be medically necessary and only the amount Medicare determines to be reasonable. (See page 22.) Most Medicare supplement policies do not pay for services Medicare finds unnecessary, or for charges in excess of Medicare's approved amount.

- **Prepayment Plans** . . . There may be one or more prepayment plans such as a health maintenance organization (HMO) or competitive medical plan (CMP) in your area which participate in the Medicare program. Prepayment plans both insure health care and provide health care services. People who join are required to receive health services directly from physicians and other

providers affiliated with the plan, except in an emergency. Be aware, however, that as a Medicare beneficiary you are not eligible for enrollment in a prepayment plan unless you reside in the plan's service area and are enrolled in Medicare Part B. If you enroll in a prepayment plan, Medicare pays the plan a fixed amount each month to provide you with all Medicare-approved services. You may be required to pay the plan a monthly premium that covers the cost of deductibles and copayments that would be your responsibility under Medicare if you were not a member of a prepayment plan. However, depending on the plan, there may not be an extra premium and the plan may offer services beyond those covered by Medicare. Services are prepaid, so there are usually no claims forms to process. If you enroll in a prepayment plan you may not need Medicare supplement insurance.

Group insurance is available through employers and voluntary associations.

- **Employer Group Insurance** . . . Many people are covered by a group plan while they are employed. Find out before you retire if your group coverage can be continued or converted to a suitable individual Medicare supplement policy when you reach age 65. Check carefully the price and the benefits, including benefits for your spouse. Employer group insurance that is continued or converted after retirement usually has the advantage of having no waiting periods or preexisting condition exclusions. Consult your employer for information about special

rules that apply to employer group coverage for people who continue to work after they reach age 65.

If you are 65 or older and insured by an employer health plan either through your current employment or the current employment of a spouse of any age, you have the choice of using either the employer plan (if the employer has at least 20 employees) or Medicare as your primary health insurance. If you choose the employer plan it will be the primary payer of your hospital and medical bills and Medicare will be the secondary payer. In other words, if your employer plan does not pay all of the charges, Medicare may pay some of the charges for Medicare-covered services. If you do not choose your (or your spouse's) employer plan, Medicare will become the primary payer of any covered health services and supplies you receive. If you choose Medicare as the primary payer you must so notify your employer, and the employer plan is not permitted to pay supplemental benefits for Medicare-covered services. However, your employer may offer a plan that pays for health care services not covered by Medicare, such as hearing aids and routine dental care.

Duplicative Employer Benefits . . . If you are a Medicare beneficiary covered by a supplemental employer plan and Medicare is your primary payer, your employer may need to adjust your coverage under the plan to make it consistent with the new Medicare Catastrophic Coverage Act. Some employers whose plans significantly duplicate the new Medicare coverage are required to provide refunds, additional benefits, or

a combination of the two. If your plan is affected by the new law, information regarding changes in the plan will be available from your employer.

- **Association Group Insurance** . . . Many organizations, other than employers, offer various kinds of group health insurance coverage to their members over age 65. Beware of claims of low group rates because coverage under group policies may be as expensive or more costly than comparable coverage under individual policies. Be sure you understand the benefits included and then compare prices.

The following types of coverage are generally limited in scope and are not substitutes for Medicare supplement insurance, prepayment plans or long-term care insurance.

- **Nursing Home Coverage** . . . Most people who enter nursing homes do so to receive custodial care, which is not covered by Medicare or most Medicare supplement policies. The only care in nursing homes that Medicare covers is skilled nursing care or skilled rehabilitative care which is provided in a skilled nursing facility (SNF). (See page 19 for a description of skilled nursing facility care.) To qualify for Medicare coverage for skilled nursing facility care, your primary need must be for daily skilled nursing or skilled rehabilitative therapy at least five times per week. The daily skilled services must be ones which, as a practical matter, can only be provided on an inpatient basis. The services must also be provided in a Medicare-certified skilled nursing facility. Until 1989, Medicare

also required a three-day prior hospital stay in order for a stay in a skilled nursing facility to be covered, but that requirement was removed by the Medicare Catastrophic Coverage Act.

When your State adopts the new minimum benefit standards established by the NAIC, all new Medicare supplement policies issued in the state will be required to cover the Medicare co-payment for the first eight days of approved care in a skilled nursing facility. (See pages 8 through 9 for a discussion of new minimum benefit standards for Medicare supplement policies.) While skilled nursing facility coverage was not required before 1989, it was included in some Medicare supplement policies. Those policies usually pay only the co-payments associated with days of care for which Medicare pays.

When Medicare coverage for skilled nursing facility care ends because the patient no longer requires this level or intensity of care, coverage under existing (pre-1989) Medicare supplement policies usually also stops. This may also be the case for policies issued under the new minimum benefit standards.

There are, however, insurance policies which you can buy to cover custodial care, care in an intermediate care facility (ICF), or skilled nursing facility care beyond that covered by Medicare. One such policy is a long term care policy. Many new long term care insurance products have been coming onto the market in the last few years. Some of these offer considerably better

coverage than the older types of nursing home insurance which used to be the only coverage available. Some of the newer types of long term care policies will also cover some in-home care beyond that which Medicare provides under the Home Health benefit.

If you are in the market for nursing home coverage or long term care insurance, be sure you know which types of nursing homes and services are covered by the different policies available, by Medicare, and by any Medicare supplement insurance you may have. If you purchase nursing home or long term care insurance (or have existing nursing home coverage) you should make sure that you are not duplicating skilled nursing facility coverage provided by any Medicare supplement policy or prepayment plan coverage you may have.

- **Hospital Confinement Indemnity Coverage** . . . Pays a fixed amount for each day you are hospitalized up to a designated number of days. Some coverage may have added benefits such as surgical benefits or skilled nursing home confinement benefits.

- **Specified Disease Coverage** . . . (Not available in some states) . . . provides benefits for only a single disease, such as cancer, or a group of specified diseases. The value of such coverage depends on the chance you will get the specific disease or diseases covered. Benefits are usually limited to payment of a fixed amount for each type of treatment. Benefits are not designed to fill the Medicare gaps.

WHAT MEDICARE PAYS AND DOESN'T PAY—Medicare is divided into two parts—Hospital insurance (Part A) and medical insurance (Part B). Pages 18 to 20 describe Part A benefits and pages 20 through 21 describe Part B benefits. The chart on pages 16 and 17 gives brief outlines of both Part A and Part B. Please refer to *The Medicare Handbook* or any Social Security office for more information.

Medicare does not pay the entire cost for all services covered by the program. You or your insurance company must pay certain deductibles and co-payments. A deductible is an initial dollar amount which Medicare does not pay . . . a co-payment is your share of expenses for covered services above the deductible.

The following chart describes Medicare only. The "You Pay" column itemizes expenses you are responsible for and must pay out of your own pocket or through the purchase of some type of private coverage as described in this pamphlet.

MEDICARE (PART A): HOSPITAL INSUR	
Service	**Benef**
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	Unlimited days reasonable and care
SKILLED NURSING FACILITY CARE . . .	First 8 days
In a facility approved by Medicare. (1)	Additional 142 days
HOME HEALTH CARE	Visits limited to medically necess care
HOSPICE CARE Available to terminally ill	As long as docto certifies need
BLOOD	Blood

* These figures are for 1989 and are subject to change each
** If you pay the deductible during December, you do not the hospital in January of the following year.

(1) Medicare and private insurance will not pay for most nur nursing home.

MEDICARE (PART B): MEDICAL INSURA	
Service	**Bene**
MEDICAL EXPENSE Physician's services, inpatient and outpatient medical services and supplies, physical and speech therapy, ambulance, etc.	Medicare pays fo medical services out of the hospit
HOME HEALTH CARE	Visits limited to necessary skilled
OUTPATIENT HOSPITAL TREATMENT	Unlimited if med necessary
BLOOD	Blood

* Once you have had $75 of expense for covered services in covered services you receive for the rest of the year.
** YOU PAY FOR charges higher than the amount approved Medicare's approved amount as the total charge for service

—COVERED SERVICES PER CALENDAR YEAR

	Medicare Pays*	You Pay*
ty	All but $560 of first hospital stay	$560 of first stay each calendar year**
	All but $25.50 a day	$25.50 a day for the first 8 days
	All	
led	Full cost of services 80% of approved amount for durable medical equipment	Nothing for services 20% of approved amount for durable medical equipment
	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
	All but first 3 pints	For first 3 pints

pay it again if you remain a patient in or are readmitted to

me care. You pay for custodial care and most care in a

COVERED SERVICES PER CALENDAR YEAR

	Medicare Pays	You Pay
	80% of approved amount (after $75 deductible)	$75 deductible* plus 20% of balance of approved amount (plus any charge above approved amount)**
lly	Full cost of services 80% of approved amount for durable medical equipment (after $75 deductible)	Nothing for services 20% of approved amount for durable medical equipment (after $75 deductible)
	80% of approved amount (after $75 deductible)	Subject to deductible plus 20% of balance of approved amount
	80% of approved amount (after $75 deductible and starting with 4th pint)	First 3 pints plus 20% of approved amount (after $75 deductible)

ne Part B deductible does not apply to any further

dicare unless the doctor or supplier agrees to accept
ered. (See page 22.)

MEDICARE (PART A): HOSPITAL INSURANCE—COVERED SERVICES PER CALENDAR YEAR

Service	Benefit	Medicare Pays*	You Pay*
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	Unlimited days of reasonable and necessary care	All but $560 of first hospital stay	$560 of first stay each calendar year**
SKILLED NURSING FACILITY CARE . . . In a facility approved by Medicare. (1)	First 8 days	All but $25.50 a day	$25.50 a day for the first 8 days
	Additional 142 days	All	
HOME HEALTH CARE	Visits limited to medically necessary skilled care	Full cost of services 80% of approved amount for durable medical equipment	Nothing for services 20% of approved amount for durable medical equipment
HOSPICE CARE Available to terminally ill	As long as doctor certifies need	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
BLOOD	Blood	All but first 3 pints	For first 3 pints

* These figures are for 1989 and are subject to change each year.

** If you pay the deductible during December, you do not have to pay it again if you remain a patient in or are readmitted to the hospital in January of the following year.

(1) Medicare and private insurance will not pay for most nursing home care. You pay for custodial care and most care in a nursing home.

MEDICARE (PART B): MEDICAL INSURANCE—COVERED SERVICES PER CALENDAR YEAR

Service	Benefit	Medicare Pays	You Pay
MEDICAL EXPENSE Physician's services, inpatient and outpatient medical services and supplies, physical and speech therapy, ambulance, etc.	Medicare pays for medical services in or out of the hospital.	80% of approved amount (after $75 deductible)	$75 deductible* plus 20% of balance of approved amount (plus any charge above approved amount)**
HOME HEALTH CARE	Visits limited to medically necessary skilled care	Full cost of services 80% of approved amount for durable medical equipment (after $75 deductible)	Nothing for services 20% of approved amount for durable medical equipment (after $75 deductible)
OUTPATIENT HOSPITAL TREATMENT	Unlimited if medically necessary	80% of approved amount (after $75 deductible)	Subject to deductible plus 20% of balance of approved amount
BLOOD	Blood	80% of approved amount (after $75 deductible and starting with 4th pint)	First 3 pints plus 20% of approved amount (after $75 deductible)

* Once you have had $75 of expense for covered services in 1989, the Part B deductible does not apply to any further covered services you receive for the rest of the year.

** YOU PAY FOR charges higher than the amount approved by Medicare unless the doctor or supplier agrees to accept Medicare's approved amount as the total charge for services rendered. (See page 22.)

MEDICARE HOSPITAL INSURANCE BENEFITS (PART A)

What Medicare Part A Pays

When all program requirements are met, Medicare Part A will help pay for medically necessary care in a hospital, for medically necessary inpatient care in a skilled nursing facility, and for hospice care. In addition, Part A pays the full cost of medically necessary home health care and 80% of the approved cost for durable medical equipment supplied under the home-health benefit.

Part A covers all services customarily furnished by hospitals and skilled nursing facilities. Part A does not cover private duty nursing, charges for a private room, unless medically necessary, or convenience items such as a telephone or television. Part A also does not cover the first 3 pints of blood you receive during an inpatient stay. However, you cannot be charged for blood if it is replaced by a blood plan or through a blood donation in your behalf.

INPATIENT HOSPITAL CARE

Part A pays for all covered services for approved inpatient hospital care after you pay a single annual deductible. The deductible for the 1989 calendar year is $560. Once the deductible is met, Medicare pays for all medically necessary inpatient hospital care for the remainder of the calendar year. This is regardless of the costs, length of stay or number of times you are admitted to the hospital during the year. And if you pay the deductible during December, you do not have to pay it again if you are still a patient in or are readmitted to the hospital in January of the following year.

SKILLED NURSING FACILITY CARE

Part A covers up to 150 days of skilled nursing facility care each calendar year and pays for all covered services except for a co-payment in 1989 of $25.50 for each of the first 8 days of care.

A skilled nursing facility is a special kind of facility which primarily furnishes skilled nursing and rehabilitation services. It may be a separate facility or part of a hospital. Medicare benefits are payable only if the skilled nursing facility is certified by Medicare and the patient requires a skilled level of care. Most nursing homes in the United States are not skilled nursing facilities and many skilled nursing facilities are not certified by Medicare.

Medicare will not pay for your stay in a skilled nursing facility if the services you receive are mainly personal care or custodial services, such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine.

HOME HEALTH CARE

Part A pays the cost of medically necessary home health visits for homebound beneficiaries. Part A covers the intermittent services of a skilled nurse, and physical and speech therapist services furnished by a Medicare-certified home health agency. If you require any of these services and are confined to your home, Part A can also cover part-time or intermittent home health aide and skilled nursing services, occupational therapy, medical social services, medical supplies and a portion of the cost of durable medical equipment. Part A does not cover full-time nursing care, drugs, meals delivered to your home or homemaker services that are primarily to assist you in meeting personal care or housekeeping needs.

HOSPICE CARE

Medicare beneficiaries certified as terminally ill may elect to receive hospice care for an unlimited duration under Part A in lieu of other Medicare benefits. Part A pays the full cost of all medical and support services necessary for the symptom management and pain relief of a terminal illness. Covered services include the following when provided by a Medicare-certified hospice: physician services, nursing care, medical appliances and supplies (including outpatient drugs for symptom management and pain relief), short-term inpatient care, counseling, therapies, and home health aide and homemaker services. There are no deductibles or co-payments except for limited cost sharing for outpatient drugs and inpatient respite care.

MEDICARE MEDICAL INSURANCE BENEFITS (PART B)

What Medicare Part B Pays

Medicare Part B helps pay for doctors' bills and many other medical services. You are automatically enrolled in Part B when you enroll in Part A unless you state that you don't want it.

YOU DON'T HAVE TO PURCHASE PART B . . . BUT IT IS AN EXCELLENT BUY BECAUSE THE FEDERAL GOVERNMENT PAYS ABOUT THREE-QUARTERS OF THE ACTUAL COST. IF YOU ARE ENROLLED IN PART A ONLY AND WANT TO ENROLL IN PART B, YOU MAY DO SO DURING THE GENERAL ENROLLMENT PERIOD FROM JANUARY 1 THROUGH MARCH 31 EACH YEAR.

When you use your Part B benefits, you will be required to pay the first $75 (the

deductible) of charges approved by Medicare. After that, Medicare Part B generally pays 80% of the amount Medicare approves for covered services you receive the rest of the year. You pay the remaining 20%. This is the Part B co-payment. Unless your doctor or supplier accepts assignment (see page 22), you are responsible for charges above the amount Medicare approves.

SERVICES COVERED

- Physicians' and surgeons' services no matter where you receive them . . . at home, in the doctor's office, in a clinic or hospital. Routine physical exams are excluded.
- Home health visits . . . If you do not have Medicare Part A, then Part B pays the full cost of medically necessary home health visits for patients requiring skilled care. You have no deductible or co-payment except with respect to 20% of the cost of durable medical equipment supplied under the home health benefit.
- Physical therapy and speech pathology services in a doctor's office, as an outpatient, or in your home.
- Other medical services and supplies . . . such as outpatient hospital services; X-rays and laboratory tests; certain ambulance services; and purchase or rental of durable medical equipment, such as wheelchairs.

Part B will not pay for any services which Medicare does not consider medically necessary . . . neither will most insurance policies.

APPROVED AMOUNT

In deciding whether a charge is "reasonable" Medicare reviews each year the usual charges of doctors or suppliers for each covered service and the charges of other doctors and suppliers in the area for the same service. The amount approved in payment for a claim is often lower than the actual charge made by the doctor or supplier.

Many Medicare supplement insurance policies only pay the Medicare co-payment that you are responsible for; that is, 20% of Medicare's approved amount. You might not get 100% coverage for your Part B bills even if you have Medicare Part B and private insurance. Here's how this could happen:

Suppose your doctor charges you $400 for an operation and Medicare determines the approved amount to be $300. Assuming you have already met the annual Part B deductible, Medicare would pay 80% of the $300, or $240. Most insurance policies would pay 20% of the $300, or $60. You would pay $100—the difference between your doctor's actual charge and Medicare's approved amount. However, you may avoid this extra payment if your doctor accepts assignment.

ASK ABOUT ASSIGNMENT AND PARTICIPATING DOCTORS OR SUPPLIERS

Because you can't tell in advance whether the approved amount and the actual charge for covered services and supplies will be the same, always ask your doctors or medical suppliers, such as laboratories and therapists, if they accept assignment of Medicare benefits. Assignment means that the doctor or supplier will accept

Medicare's approved amount as full payment and cannot legally bill you for anything above that amount. In the example above, if your doctor agreed to assignment, he or she would accept $300 as payment in full and you would not have to pay the $100 difference. Doctors and suppliers do not have to accept assignment, but many do.

Also, doctors and suppliers can now become Medicare-participating doctors or suppliers who agree to accept assignment on all Medicare claims. These doctors and suppliers are listed in *The Medicare Participating Physician/Supplier Directory* which is distributed to senior citizen organizations, all local Social Security and Railroad Retirement offices, all hospitals, and all State and area offices of the Administration on Aging. This directory can be obtained free of charge from the insurance carrier that processes Medicare Part B claims in your area (see the back of The Medicare Handbook for the list of carrier addresses) or you can call the carrier to find out which doctors and suppliers are participating.

EXPENSES NOT COVERED BY MEDICARE—Medicare does not cover certain kinds of care, charges or supplies. Most private insurance does not cover them either. Among them are:

- Private duty nursing.
- Skilled nursing home care costs beyond 150 days a year.
- Custodial care in a nursing home or at home.
- Intermediate nursing home care.
- Physician charges above Medicare's approved amount.

- Outpatient drugs (other than those which cannot be self-administered and are provided incident to a physician's services; outpatient drugs for symptom management or pain relief provided by a hospice; and immunosuppressive drugs under certain circumstances.)
- Care received outside the USA, except under limited circumstances in Canada and Mexico.
- Dental care or dentures, checkups, most routine immunizations, cosmetic surgery, routine foot care, examinations for and the cost of eyeglasses or hearing aids.

PAYING FOR MEDICARE . . . Part A is financed through part of the Social Security (FICA) tax paid by all workers and their employers. You do not have to pay a monthly premium for Medicare Part A if you or your spouse are entitled to benefits under either the Social Security or Railroad Retirement systems, or worked a sufficient period of time in Federal, State, or local government employment to be insured. Some disabled persons who do not meet the age requirement of 65 may also qualify for benefits. If you do not meet the qualifications for Part A benefits, you may purchase the coverage if you are at least 65 years old. The monthly premium is estimated at $156 in 1989.

SUPPLEMENTAL PREMIUM

A new supplemental premium based on Federal income tax liability will be in effect for the 1989 tax year to pay for new and expanded benefits enacted in the Medicare Catastrophic Coverage Act of 1988. You will be required to pay the supplemental premium as part of your income tax if you

are entitled to or eligible for Medicare Part A for more than six full months in the taxable year and your Federal income tax liability for the year is $150 or more. If it is less, or if you purchase Part A coverage, you do not have to pay the supplemental premium. The supplemental premium rate is $22.50 for each $150 of Federal income tax liability for the 1989 tax year. The maximum premium for an individual in 1989 is $800. The maximum is double for a couple if both spouses are eligible for Part A.

If you have a tax-related question about the supplemental premium, you should call or visit your local Internal Revenue Service office.

Part B is optional and is offered to all beneficiaries when they enroll in Part A. It also may be purchased by individuals who do not qualify for Part A. The monthly basic Part B premium is $27.90 in 1989. Effective January 1, 1989, a flat premium of $4 per month will be added to the basic Part B premium to help pay for the new catastrophic coverage that will be phased in beginning in 1989. The flat premium will be $1.30 per month for a resident of Puerto Rico and $2.10 a month for a resident of another U.S. commonwealth or territory. The flat premium will be subject to change each year, as is the basic Part B premium.

FOR ADDITIONAL HELP. . . If you need additional help or advice on Medicare benefits or eligibility, contact your nearest Social Security office or the Medicare insurance carrier in your area.

For information on private insurance to supplement Medicare, check your State Insurance Department or State Agency on Aging. (See the lists in the back of this pamphlet.)

If you bought or are considering buying a health insurance policy, the company or its agent should answer your questions. If you do not get the service you feel you deserve, discuss the matter with your State Insurance Department.

STATE INSURANCE REGULATORS

Each State has its own laws and regulations governing all types of insurance. The offices listed in this section are responsible for enforcing these laws, as well as providing the public with information about insurance.

Alabama
Alabama Insurance Department
135 South Union Street
Montgomery, AL 36130–3401
205/269–3550

Alaska
Alaska Insurance Department
3601 C Street, Suite 722
Anchorage, AK 99503
907/562–3626

American Samoa
American Samoa Insurance Department
Office of the Governor
Pago Pago, AS 96797
011–684/633–4116

Arizona
Arizona Insurance Department
Consumer Affairs and Investigation Division
3030 N. Third Street
Phoenix, AZ 85012
602/255–4783

Arkansas
Arkansas Insurance Department
Consumer Service Division
400 University Tower Bldg.
12th and University Streets
Little Rock, AR 72204
501/371–1813

California
California Insurance Department
Consumer Services Division
100 Van Ness Avenue
San Francisco, CA 94102
1–800–233–9045
or
600 S. Commonwealth Avenue
Los Angeles, CA 90005
1–800–233–9045

Colorado
Colorado Insurance Division
303 West Colfax Avenue
5th Floor
Denver, CO 80204
303/620–4300

Connecticut
Connecticut Insurance Department
165 Capitol Avenue
State Office Building
Room 425
Hartford, CT 06106
203/566–5275

Delaware
Delaware Insurance Department
841 Silver Lake Boulevard
Dover, DE 19901
302/736–4251

District of Columbia
District of Columbia Insurance
614 H Street, NW
Suite 512
Washington, DC 20001
202/783–3191

Florida
Florida Department of Insurance
State Capitol
Plaza Level Eleven (11)
Tallahassee, FL 32399–0300
904/488–0030

Georgia
Georgia Insurance Department
2 Martin L. King, Jr., Dr.
7th Floor West Tower
Atlanta, GA 30334
404/656–2056

Guam
Guam Insurance Department
P.O. Box 2796
Agana, Guam 96910
or
855 West Marine Drive
011–671/477–1040
(22 hrs. earlier than CST)

Hawaii
Hawaii Department of Commerce and Consumer Affairs
Insurance Division
P.O. Box 3614
Honolulu, HI 96811
808/548-5450

Idaho
Idaho Insurance Department
Public Service Department
500 South 10th Street
Boise, ID 83720
208/334-2250

Illinois
Illinois Insurance Department
320 West Washington Street
4th Floor
Springfield, IL 62767
217/782-4515

Indiana
Indiana Insurance Department
311 West Washington Street
Suite 300
Indianapolis, IN 46204
317/232-2395

Iowa
Iowa Insurance Division
Lucas State Office Bldg.
E. 12th & Walnut Sts.
6th Floor
Des Moines, IA 50319
515/281-5705

Kansas
Kansas Insurance Department
420 S.W. 9th Street
Topeka, KS 66612
913/296-3071

Kentucky
Kentucky Insurance Department
229 West Main Street
P.O. Box 517
Frankfort, KY 40602
502/564-3630

Louisiana
Louisiana Insurance Department
P.O. Box 94214
Baton Rouge, LA 70804-9214
504/342-5900

Maine
Maine Bureau of Insurance
Consumer Division
State House, Station 34
Augusta, ME 04333
207/582-8707

Maryland
Maryland Insurance Department
Complaints and Investigation Unit
501 St. Paul Place
Baltimore, MD 21202-2272
301/333-2792

Massachusetts
Massachusetts Insurance Division
Consumer Services Section
280 Friend Street
Boston, MA 02114
617/727-3357

Michigan
Michigan Insurance Department
P.O. Box 30220
Lansing, MI 48909
517/373-0220

Minnesota
Minnesota Insurance Department
Department of Commerce
500 Metro Square Building
Junction of 7th & Roberts Sts.
St. Paul, MN 55101
612/296-4026

Mississippi
Mississippi Insurance Department
Consumer Assistance Division
P.O. Box 79
Jackson, MS 39205
601/359-3569

Missouri
Missouri Division of Insurance
Consumer Services Section
P.O. Box 690
Jefferson City, MO
65102-0690
314/751-2640

Montana
Montana Insurance Department
126 North Sanders
Mitchell Building
P.O. Box 4009, Room 270
Helena, MT 59604
406/444-2040

Nebraska
Nebraska Insurance Department
Terminal Building
941 O Street, Suite 400
Lincoln, NE 68508
402/471–2201

Nevada
Nevada Department of Commerce
Insurance Division
Consumer Section
201 South Fall Street, Room 316
Carson City, NV 89701
702/885–4270

New Hampshire
New Hampshire Insurance Department
Life and Health Division
169 Manchester Street
Concord, NH 03301
603/271–2261

New Jersey
New Jersey Insurance Department
20 West State Street
Roebling Building
Trenton, NJ 08625
609/292–4757

New Mexico
New Mexico Insurance Department
P.O. Box 1269
Santa Fe, NM 87504–1269
505/827–4500

New York
New York Insurance Department
160 West Broadway
New York, NY 10013
New York City
212/602–0203
Toll Free (within State outside of NYC)
1–800–342–3736

North Carolina
North Carolina Insurance Department
Consumer Insurance Information
Dobbs Building
P.O. Box 26387
Raleigh, NC 27611
919/733–2004

North Dakota
North Dakota Insurance Department
Capitol Building
Fifth Floor
Bismarck, ND 58505
701/224–2440

Ohio
Ohio Insurance Department
Consumer Services Division
2100 Stella Court
Columbus, OH 43215
614/644–2673

Oklahoma
Oklahoma Insurance Department
P.O. Box 53408
Oklahoma City, OK 73152–3408
405/521–2828

Oregon
Oregon Department of Insurance and Finance
Insurance Division/Consumer Advocate
21 Labor and Industry Bldg.
Salem, OR 97310
503/378–4484

Pennsylvania
Pennsylvania Insurance Department
1326 Strawberry Square
Harrisburg, PA 17120
717/787–3289

Puerto Rico
Puerto Rico Insurance Department
Fernandez Juncos Station
P.O. Box 8330
Santurce, PR 00910
809/722–8686

Rhode Island
Rhode Island Insurance Division
233 Richmond Street
Suite 233
Providence, RI 02903–4233
401/277–2223

South Carolina
South Carolina Insurance Department
Consumer Assistance Section
P.O. Box 100105
Columbia, SC 29202–3105
803/737–6140

South Dakota
South Dakota Insurance Department
Enforcement
500 E. Capitol
Pierre, SD 57501
605/773–3563

Tennessee
Tennessee Insurance Department
Department of Commerce and Insurance
Policyholders Service Section
1880 West End Avenue
14th Floor
Nashville, TN 37219–5318
1–800–342–4031

Texas
Texas Board of Insurance
Complaints Division
1110 San Jacinto Blvd.
Austin, TX 78701–1998
512/463–6501

Utah
Utah Insurance Department
Consumer Services
P.O. Box 45803
Salt Lake City, UT 84145
801/530–6400

Vermont
Vermont Department of Banking and Insurance
Consumer Complaint Division
120 State Street
Montpelier, VT 05602
802/828–3301

Virgin Islands
Virgin Islands Insurance Department
Kongens Garde No. 18
St. Thomas, VI 00802
809/774–2991

Virginia
Virginia Insurance Department
Consumer Services Division
700 Jefferson Building
P.O. Box 1157
Richmond, VA 23209
804/786–7691

Washington
Washington Insurance Department
Insurance Building AQ21
Olympia, WA 98504
206/753–7300

West Virginia
West Virginia Insurance Department
2019 Washington Street, E
Charleston, WV 25305
304/348–3386

Wisconsin
Wisconsin Insurance Department
Complaints Department
P.O. Box 7873
Madison, WI 53707
608/266–0103

Wyoming
Wyoming Insurance Department
Herschler Building
122 West 25th Street
Cheyenne, WY 82002
307/777–7401

The offices listed in this section are responsible for coordinating services for older Americans.

Alabama
Alabama Commission on Aging
136 Catoma Street
Montgomery, AL 36130
Toll Free (Within State)
1–800–243–5463
(205) 261–5743

Alaska
Older Alaskans Commission
P.O. Box C, MS 0209
Juneau, AK 99811
(907) 465–3250

American Samoa
Territorial Administration on Aging
Government of American Samoa
Pago Pago, AS 96799
(684) 633–1251

Arizona
Department of Economic Security
Aging and Adult Administration
1400 W. Washington Street
Phoenix, AZ 85007
(602) 254–4446

Arkansas
Division of Aging and Adult Services
Donaghey Plaza South,
Suite 1417
7th and Main Streets
P.O. Box 1437/Slot 1412
Little Rock, AR 72203–1437
(501) 682–2441

California
Department of Aging
1600 K Street
Sacramento, CA 95814
(916) 322–3887

Colorado
Aging and Adult Services
Department of Social Services
1575 Sherman St., 10th Floor
Denver, CO 80203–1714
(303) 866–5905

Commonwealth of the Northern Mariana Islands
Department of Community and Cultural Affairs
Civic Center
Commonwealth of the Northern Mariana Islands
Saipan, CM 96950
(670) 234–6011

Connecticut
Department on Aging
175 Main Street
Hartford, CT 06106
Toll Free (Within State)
1–800–443–9946
(203) 566–7772

Delaware
Division of Aging
Department of Health and Social Services
1901 N Dupont Highway
New Castle, DE 19720
(302) 421–6791

District of Columbia
Office on Aging
Executive Office of the Mayor
1424 K Street, NW.
2nd Floor
Washington, DC 20005
(202) 724–5626
(202) 724–5622

Federated States of Micronesia
State Agency on Aging
Office of Health Services
Federated States of Micronesia
Ponape, E.C.I. 96941

Florida
Florida Department of Insurance
The Capitol
Tallahassee, FL 32301
Toll Free (Within State)
1–800–342–2762

Georgia
Office of Aging
Department of Human Resources
878 Peachtree Street, NE.
Room 632
Atlanta, GA 30309
(404) 894–5333

Guam
Division of Senior Citizens
Department of Public Health
and Social Services
P.O. Box 2816
Agana, GU 96910
(671) 734–2942

Hawaii
Executive Office on Aging
335 Merchant Street
Room 241
Honolulu, HI 96813
(808) 548–2593

Idaho
Office on Aging
Statehouse, Room 114
Boise, ID 83720
(208) 334–3833

Illinois
Department on Aging
421 East Capitol Avenue
Springfield, IL 62701
(217) 785–2870

Indiana
Department of Human
Services
251 North Illinois
P.O. Box 7083
Indianapolis, IN 46207–7083
(317) 232–1139

Iowa
Department of Elder Affairs
Suite 236, Jewett Building
914 Grand Avenue
Des Moines, IA 50319
(515) 281–5187

Kansas
Department on Aging
122–S, Docking State
Office Bldg.
915 SW Harrison
Topeka, KS 66612–1500
(913) 296–4986

Kentucky
Division for Aging Services
Department for Social Services
275 East Main Street
Frankfort, KY 40621
(502) 564–6930

Louisiana
Governor's Office of
Elderly Affairs
P.O. Box 80374
Baton Rouge, LA 70898–0374
(504) 925–1700

Maine
Maine Committee of Aging
State House, Station 127
Augusta, ME 04333
(207) 289–3658

Maryland
State Agency on Aging
301 West Preston Street
Baltimore, MD 21201
(301) 225–1102

Massachusetts
Executive Office of
Elder Affairs
38 Chauncy Street
Boston, MA 02111
Toll Free (Within State)
1–800–882–2003
(617) 727–7750

Michigan
Office of Services to the Aging
P.O. Box 30026
Lansing, MI 48909
(517) 373–8230

Minnesota
Minnesota Board on Aging
Metro Square Building
Suite 204
121 East Seventh Street
St. Paul, MN 55101
(612) 296–2770

Mississippi
Council on Aging
301 West Pearl Street
Jackson, MS 39203–3092
Toll Free (Within State)
1–800–222–7622
(601) 949–2070

Missouri
Missouri Division of Insurance
Truman Building 630
P.O. Box 690
Jefferson, MO 65102–0690
Toll Free (Within State)
1–800–235–5503

Montana
Department of Family Services
P.O. Box 8005
Helena, MT 59604
(406) 444–5900

Nebraska
Department on Aging
Legal Services Developer
State Office Building
301 Centennial Mall South
Lincoln, NE 68509
(402) 471–2306

Nevada
Department of Human Resources
Division for Aging Services
505 East King Street
Room 101
Carson City, NV 89710
(702) 885–4210

New Hampshire
Department of Health and Human Services
Division of Elderly and Adult Services
6 Hazen Drive
Concord, NH 03301
(603) 271–4390

New Jersey
Department of Community Affairs
Division on Aging
South Broad and Front Sts.
CN 807
Trenton, NJ 08625–0807
(609) 292–0920

New Mexico
Agency on Aging
La Villa Rivera Bldg.
4th Floor
224 East Palace Avenue
Santa Fe, NM 87501
Toll Free (Within State)
1–800–432–2080
(505) 827–7640

New York
State Office for the Aging
Agency Building
#2 Empire State Plaza
Albany, NY 12223–0001
Toll Free (Within State)
1–800–342–9871
(518) 474–5731

North Carolina
Department of Human Resources
Division of Aging
1985 Umstead Drive
Raleigh, NC 27603
(919) 733–3983

North Dakota
Department of Human Services
Aging Services Division
State Capitol Building
Bismarck, ND 58505
(701) 224–2577

Ohio
Department of Aging
50 West Broad Street
9th Floor
Columbus, OH 43266–0501
(614) 466–1220

Oklahoma
Department of Human Services
Aging Services Division
P.O. Box 25352
Oklahoma City, OK 73125
(405) 521–2327

Oregon
Department of Human Resources
Senior Services Division
313 Public Service Building
Salem, OR 97310
Toll Free (Within State)
1–800–232–3020
(503) 378–4636

Palau
State Agency on Aging
Department of Social Services
Republic of Palau
Koror, Palau 96940

Pennsylvania
Department of Aging
231 State Street
Barto Building
Harrisburg, PA 17101
(717) 783–1550

Puerto Rico
Governors Office of Elderly Affairs
Gericulture Commission
Box 11398
Santurce, PR 00910
(809) 722–2429 or 722–0225

Republic of the Marshall Islands
State Agency on Aging
Department of Social Services
Republic of the Marshall Islands
Marjuro, Marshall Islands 96960

Rhode Island
Department of Elderly Affairs
79 Washington Street
Providence, RI 02903
(401) 277–2858

South Carolina
Commission on Aging
400 Arbor Lake Drive
Suite B–500
Columbia, SC 29223
(803) 735–0210

South Dakota
Agency on Aging
Adult Services and Aging
Richard F. Kneip Building
700 Governors Drive
Pierre, SD 57501–2291
(605) 773–3656

Tennessee
Commission on Aging
Commerce and Insurance
Department
Volunteer Plaza
James Robinson Parkway
Nashville, TN 37219–5573
(615) 741–2241

Texas
Department on Aging
P.O. Box 12786
Capitol Station
Austin, TX 78711
(512) 444–2727

Utah
Division of Aging &
Adult Services
120 North 200 West
Post Office Box 45500
Salt Lake City, UT 84145–0500
(801) 538–3910

Vermont
Office on Aging
Waterbury Complex
103 S. Main Street
Waterbury, VT 05676
(802) 241–2400

Virgin Islands
Department of Human
Services
Barbel Plaza South
Charlotte Amalie
St. Thomas, VI 00802
(809) 774–0930

Virginia
Department for the Aging
18th Floor
101 North 14th Street
Richmond, VA 23219
Toll Free (Within State)
1–800–552–4464
(804) 225–2271

Washington
Aging & Adult Services
Administration
Department of Social &
Health Services
Mail Stop OB–44–A
Olympia, WA 98504
(206) 586–3768

West Virginia
Commission on Aging
State Capitol Complex
Holly Grove
Charleston, WV 25305
Toll Free (Within State)
1–800–642–3671
(304) 348–3317

Wisconsin
Bureau on Aging
Department of Health and
Social Services
P.O. Box 7851
Madison, WI 53707
Toll Free (Within State)
1–800–242–1060
(608) 266–2536

Wyoming
Commission on Aging
Hathaway Building
First Floor
Cheyenne, WY 82002
Toll Free (Within State)
1–800–442–2766
(307) 777–7986

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CMS Library
C2-07-13
7500 Security Blvd.
Baltimore, Maryland 21244

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration
Publication No. HCFA 02110

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
BALTIMORE, MARYLAND 21207

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1989